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Staff Perception Related to Family Presence during Resuscitation

by

Stephanie L. Herron

A thesis submitted to the faculty of
Gardner-Webb University School of Nursing
in partial fulfillment of the
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Submitted by:

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Abstract

The purpose of this study was to examine the perception of health care professionals (staff nurses) regarding family presence during resuscitation. The sample consisted of 59 nurses of different ages and working in different departments. The Staff Perceptions of Family-Witnessed Resuscitation questionnaire was used to collect data. The relationships between participants' demographic data and perceived attitudes and beliefs were also analyzed. Many of the healthcare professionals felt that it was acceptable to have family members present during resuscitation if the patient makes clear decisions prior to the incident or if the physician makes the decision for the patient. Almost half of the healthcare professionals had invited family members to the bedside at some point during resuscitation. Factor analysis identified five factors: attitudes, values, fears, efficacy, and family behavior. The healthcare professionals did not respond as having negative attitudes or fears regarding inviting family members to the bedside during resuscitation. Males ($N = 13$) had higher scores compared to females ($N = 46$) for factors regarding healthcare professionals' attitudes and healthcare professionals' values. The results suggested that males believe that they have a more positive view towards the death/dying process. There were no differences on the factor scores based on years of experience. There were also no significant differences in the responses when comparing the different units where the nurses work or the age of the nurses. The overall results showed that the respondents have a neutral opinion on three of the five factors: attitudes, fears, and family behaviors. The data suggested that healthcare professionals have positive beliefs about their personal levels of caring and compassion.

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This thesis would not have been possible without the guidance and help of several individuals who in one way or another contributed and extended their valuable assistance in the preparation and completion of this project.

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CHAPTER I

Introduction

Cardiopulmonary resuscitation of patients occurs daily in hospitals. Cardiopulmonary resuscitation is a procedure designed to restore normal breathing after cardiac arrest that includes the clearance of air passages to the lungs, the mouth-to-mouth method of artificial respiration, and heart massage by the exertion of pressure on the chest (Merriam-Webster, 2014). Historically, many departments do not allow the family members inside the room during resuscitation efforts. There are a multitude of reasons as to why this is not allowed. The range of emotions and grief that are demonstrated by the families can be difficult to cope with by the healthcare professionals. The families' grief experience is impacted by the manner of the death and even the timing and the process. However, family presence at bedside during resuscitation can be an important component of the patient's care and the family's recovery. Some healthcare professionals feel that it is important to have families at bedside as it is helpful for the families and the patients. This practice is gaining recognition and has the potential to have a significant impact on nursing practice and personnel. Some institutions support and recommend having family members present during resuscitation as it can offer benefits to both patients and family members.

Problem Statement

Currently, there are many reasons why facilities do not allow family members at the bedside during resuscitation. Many of these reasons are based on healthcare professionals' perceptions of the process and of any perceived problems that may occur during resuscitation. Some healthcare professionals feel as though it is a very limited space in a

highly traumatizing environment. They also feel that the family may not truly understand the events and the actions of the healthcare team. Other healthcare professionals feel as though the presence of highly upset and crying family members can disturb the procedures during the resuscitation and remove the focus from the potentially life-saving events.

However, much of the literature showed that these perceptions are incorrect. Some healthcare professionals do feel as though family presence at bedside during resuscitation can help the family to have closure as they can witness everything that was done to save their family member. The family would also be present to extend love and support to the patient during this traumatic time. Others feel that if the family or the patient has requested them to be present that it should be allowed as long as the family can cope with the situation while the team works on the patient.

Significance of the Research

The first recorded incidents of family presence during resuscitation were at Foote Hospital in Jackson, MI in 1982 (Hanson & Stawser, 1992). In both incidents, the family members requested to be present during the resuscitation. When the two situations were evaluated, both the families and healthcare professionals had positive feedback. A program was implemented at Foote Hospital with a follow up survey that showed: 76% felt that their adjustment to the death was made easier by their presence in the room, 64% felt that their presence was beneficial to the dying person, and 94% believed that they would choose to be present again during Cardiopulmonary Resuscitation (CPR) if given the opportunity (Hanson & Stawser, 1992). In 1993 the Emergency Nurses Association (ENA) adopted a resolution in support of Family Presence (FP) during resuscitation as well as a

position statement in 1994. In 1995 the ENA also released an educational program entitled “Presenting the Option for Family Presence” (Eckle, 2007).

Some facilities have implemented Family Presence during Resuscitation (FPDR) programs; however, this practice still remains highly controversial. MacLean reported in 2003 regarding the state of family presence in facilities by publishing the results of a survey that had been mailed to 1,500 members of the American Association of Critical Care Nurses (AACN) and 1,500 members of the ENA (Maclean et al., 2003). Nine hundred and eighty-four surveys were returned showing: 5% of the respondents worked on units that had a written policy allowing the option of FPDR, 45% of the nurses responded that their institution did not have policies related to family presence, but their unit allowed FPDR, 29% reported that FPDR was prohibited on their unit but there was no written policy, 36% of the respondents had taken a family member to the bedside during resuscitation a mean of three times during the past year, and 31% said that a patient’s family had asked whether they could be present during CPR a mean of three times during the past year.

Purpose

The opinions of healthcare providers differ according to their profession, specialty, and level of experience. Surveys have shown that between 86% and 96% of nurses endorse FPDR compared to 50% to 79% of physicians (Critchell, 2007). A survey of 554 health professionals who had all attended at least one resuscitation showed that 43% of nurses and 20% of physicians were in favor of FPDR in adult patients (McClenathan, Torrington & Uyehara, 2002). Additional surveys showed that healthcare professionals’ attitudes towards FPDR can evolve positively over time. The purpose of this MSN thesis

was to investigate healthcare professionals' perceptions related to family presence during resuscitation.

Research Questions

This study was designed to explore the following research questions:

1. What are the most frequently perceived opinions among nursing healthcare professionals regarding FPDR?
2. What are the perceived performance behaviors that nursing healthcare professionals feel they can comfortably complete with FPDR?
3. What are the relationships between selected demographic characteristics and perceived opinions?

Theoretical or Conceptual Framework

The theoretical framework guiding this project is Jean Watson's Theory of Caring. According to Jean Watson (1988), the word nurse is both noun and verb. To her, nursing consists of knowledge, thought, values, philosophy, commitment, and action with some degree of passion (Alligood & Tomey, 2010). Jean Watson created the Philosophy and Theory of Caring. The aim of her concept is that caring is a moral ideal: mind-body-soul, and engagement with another. According to Watson, nursing is concerned with promoting health, preventing illness, caring for the sick and restoring health (Alligood & Tomey, 2010). The concept of caring has a prominent position in nursing literature (McEwen & Willis, 2011). This theory is being validated in many clinical settings. The defining attribute of Watson's theory is authentic caring for the purpose of preserving the dignity and wholeness of humanity. This attribute is very important in regards to resuscitation efforts and procedures. The patient and family are in a life and death situation and

need the support of caring individuals. Watson sees nursing as a collective caring-healing role with a mission of attending to, and helping to sustain humanity and wholeness (Parker, 2001). Watson defines the person as a complex, holistic being; an evolving soul who has value and meaning. She believes that a human being has complex needs such as physical, psychosocial, and psychological and each person is to be cared for, nurtured, and both valued and respected (Alligood & Tomey, 2010). Watson defines health as unity and harmony within the mind, body, and soul and believes it is associated with the degree of congruence between the self as perceived and the self as experienced (Alligood & Tomey, 2010). Watson defines the environment as a caring science not only just for humanity but also for sustaining the planet as she believes that belonging is to a spirit world of nature and all living things (Alligood & Tomey, 2010).

The philosophy of caring examines the relatedness of all and includes human science, human caring processes, experiences, and phenomena. Watson's original theory included 10 Carative Factors. These factors have evolved into the following Caritas Processes: Practice of loving-kindness and equanimity within the context of caring consciousness; Being authentically present, and enabling and sustaining the deep belief system and subjective life world of self and one being cared for; Cultivation of one's own spiritual practices and transpersonal self, going beyond the ego self; Developing and sustaining a helping-trusting, authentic caring relationship; Being present to, and supportive of, the expression of positive and negative feelings as a connection with deeper spirit of self and the one-being-cared-for; Creative use of self and all ways of knowing as part of the caring process, to engage in artistry of caring-healing practices; Engaging in genuine teaching-learning experience that attends to unity of being and meaning attempting to

stay within other's frame of reference; Creating healing environment at all levels, (physical as well as non-physical, subtle environment of energy and consciousness, whereby wholeness, beauty, comfort, dignity, and peace are potentiated); Assisting with basic needs, with an intentional caring consciousness, administering 'human care essentials', which potentiate alignment of mind body spirit, wholeness, and unity of being in all aspects of care; Opening and attending to spiritual-mysterious, and existential dimensions of one's own life-death; soul care for self and the one-being-care-for (Alligood & Tomey, 2010). The theory makes the following assumptions: caring can be effectively demonstrated and practiced only interpersonally, caring involves carative factors that result in the satisfaction of human needs, effective caring promotes health and individual family growth, caring responses accept the person as they are now and as what they may become, a caring environment is one that offers the development of potential while allowing the person to choose the best action for his or herself at a given point of time, caring is more healthogenic than it is caring and the practice of caring is central to nursing (Alligood & Tomey, 2010). Jean Watson's Theory of Caring emphasizes care and compassion which values the concepts of nursing central to why nurses become nurses. A nurse is a person who cares for someone who is sick or infirm but they are also so much more. It is so important that they establish a relationship with their patients. That relationship includes the physical, intellectual, and emotional aspects of their care. Nurses should treat patients with respect and dignity and provide unconditional acceptance to the patient. These attributes are what is needed during the resuscitation process in dealing with the patients and their families. The death, dying and grieving process is important to all that are involved. A caring and compassionate nurse is vitally important during this process.

Definition of Terms

Attitudes: Are a sum of beliefs attributed to some particulars. It varies per the attributions and beliefs (Fishbein & Ajzen, 1975).

Family Member: A person older than 18 years who has an established relationship with the patient (includes patient's family, loved ones, and close friends) (Henderson & Knapp, 2006).

Family Presence (FP): The presence of family in the patient care area, in a location that affords the visual or physical contact with the patient during resuscitation events (Eckle, 2007).

Summary

Resuscitation is a very stressful and chaotic event. There are a multitude of healthcare professionals in the room each with their own given task. Many healthcare professionals worry what would happen if the family members interfere or if they distract the team members from their task. The negative outcome can be devastating even if the best of circumstances when the team has done everything that they can to resuscitate the patient.

Current evidence indicated that most families want to be present during resuscitation. The Emergency Nurses Association (ENA) developed clinical guidelines supporting the option of family presence during resuscitation and invasive procedures. Now both the American Association of Critical Care Nurses and the American Heart Association have issued guidelines supporting family presence at bedside during resuscitation (Atwood, 2005). Even with this change, many healthcare professionals are resistant to this change

in practice. There are many perceived advantages and disadvantages to this practice. This thesis will review those perceptions and opinions of nursing healthcare professionals.

CHAPTER II

Literature Review

Resuscitation of patients occurs daily in hospitals. Historically, many departments do not allow the family members inside the resuscitation room. However, in recent times that is rapidly changing. Many institutions support and recommend having family members present during resuscitation as it can offer benefits to both patients and family members. The opinions of healthcare providers differ according to their profession, specialty, and level of experience. Additional surveys showed that healthcare professionals' attitudes towards FPDR can evolve positively over time. The purpose of this MSN thesis was to investigate healthcare professionals' perceptions related to family presence during resuscitation.

Review of Literature

The purpose of this literature review was to investigate the studies on FPDR in adult populations. A secondary purpose was to discuss the perceptions of nursing healthcare professionals regarding FPDR. The studies included in this review were found by using literature searches of the CINAHL and MEDLINE databases. Key search words included family presence, resuscitation, codes, emergency department, and critical care unit.

Survey Studies Focused on Patients and their Families

Whether to allow the presence of family members during cardiopulmonary (CPR) has been a highly debated topic in recent years. Even though a great deal of evidence and professional guidelines support the option of family presence during resuscitation (FPDR), many healthcare professionals still oppose it. One of the main arguments is that

family members should not be allowed for the sake of the patient's best interests, whether it is to increase his chances of survival, respect his privacy, or leave his family with a last positive impression of him. The issue of FPDR is discussed from the patient's point of view. Since the patient requires CPR, he is invariably unconscious and therefore incompetent. The researchers discussed the Autonomy Principle and the Three-Tiered process for surrogate decision making, as well as the Beneficence Principle and showed that these are limited in providing an adequate tool for decision making. They showed that this model was more satisfactory in taking the patient's true wishes under consideration and creating a decision making process by all parties involved (Lederman, Garasic, & Piperberg, 2014).

The first recorded incidents of family presence during resuscitation were at Foote Hospital in Jackson, MI in 1982 (Hanson & Stawser, 1992). In both incidents, the family members requested to be present during the resuscitation. When the two situations were evaluated, both the families and healthcare professionals had positive feedback. A program was implemented at Foote Hospital with a follow up survey that showed: 76% felt that their adjustment to the death was made easier by their presence in the room, 64% felt that their presence was beneficial to the dying person and 94% believed that they would choose to be present again during Cardiopulmonary Resuscitation (CPR) if given the opportunity (Hanson & Stawser, 1992). In 1993 the Emergency Nurses Association (ENA) adopted a resolution in support of Family Presence (FP) during resuscitation as well as a position statement in 1994. In 1995 the ENA also released an educational program entitled "Presenting the Option for Family Presence" (Eckle, 2007).

In the first published study of families who opted to be present during resuscitation, Doyle, et al. (1987) found that if in a similar situation, 44 of 47 respondents (94%) felt that they would be likely to opt to stay in the room during resuscitation. One hundred percent of 43 family members who had witnessed resuscitation on a loved one stated they would do it again in a later study (Meyers, Eichhron, & Guzzetta, 1998).

Family presence during resuscitation efforts continues to be a controversial issue among healthcare providers. Fell (2009) explored the advantages and disadvantages to this concept from the healthcare provider and family's perspective, and addressed the patient's viewpoint. The advantages listed were emotional support for patients and families; a positive experience for families, patients, and healthcare professionals; guidance and increased understanding of the patient's condition; facilitated decision-making regarding resuscitation efforts; assisted patient's family members to know that everything was done to save their loved one. The disadvantages listed are resuscitators may be distracted by a family member's observance of their efforts, possibly impairing or interfering with the process; the fear is that family member's presence can increase the code team's anxiety, hindering their performance; actions or interventions may be misinterpreted, leading to the assumption that the code team is incompetent. The information provided demonstrated that family presence during resuscitation efforts is a necessary and ethical standard in healthcare practices today and can help nurses feel more comfortable facilitating this process.

Research suggested that family presence at the bedside during resuscitation is beneficial for both family members and healthcare professionals. Education of health care personnel will help them communicate effectively with and guide distraught family

members during a code. Family presence provides the ability to see that everything is done for the patient, a sense of closeness, decreased fear and anxiety, and a way for the families to say goodbye. Attitudes of family members also have been studied, with more than 90% of subjects favoring presence during resuscitation as a means of coping with grief, providing support and comfort, and being able to say goodbye. The hospice and palliative care have promoted the presence of family members to provide support for dying loved ones. Nurses and other health care providers can empower family members to make informed decisions regarding the care of their loved ones or share moments during times of crisis (Agard, 2008).

Mcmahon-Parkes, Moule, Berger, and Albarran (2009) found that the majority of patients supported family presence during resuscitation. Many patients felt that it was important for their families to be there to understand the situation, offer emotional support and to be a patient advocate. However, some of the patients were concerned about the welfare of their family members and their emotional behaviors and feelings. There was also a small group that was concerned that the family members' needs or feelings may take precedence over the needs of the patient.

Another study was completed by Holzhauser, Finucane, and DeVries (2006) that addressed the attitudes of families that had been present during resuscitation. The researchers found that many would choose to be involved in resuscitation again if the situation were available. The survey included asking the families if they had been invited to be present, did they feel pressured to be present, the communication provided before, during and after the incident and if healthcare professionals were supportive. Many family

members stated that they preferred to be present although they were worried about being in the way and that many were very scared and emotional.

In a study completed by Wagner (2004) the focus was on the experiences and expectations of family members during resuscitation. Findings from this study showed that many family members feel as though they lose autonomy in the resuscitation room. Also many were confused and could not determine what was really going on during the resuscitation. Families that are in crisis require reassurance and information to cope with such serious situations.

In a study conducted by Zakaria and Siddique (2008), 301 relatives were polled to find their opinions on family presence during resuscitation. The study showed discrepancies in the results regarding discouragement of family presence from the nurses but patients encouraging their families to be present. The patients felt more comfortable, safe, and secure with their family members near them. Evidence continues to show that family presence is beneficial to both the patients and their families.

Survey Studies Focused on Nursing Professionals and Physicians

Numerous studies have been completed to examine the views of healthcare professionals regarding FPDR. Itzhaki, Bar-Tal, and Barnoy (2012) discussed the views of healthcare professionals regarding the effect of family presence during resuscitation on both the healthcare professionals performing the resuscitation and the relatives who witness it. The Israel Ministry of Health has not issued guidelines on the matter, although many professional groups in different countries have recently issued position statements about the practice and have recommended new policy moves. Data was collected in Israel in 2008 from a convenience sample of 220 lay people and 201 healthcare professionals

(52 physicians and 149 nurses) using a questionnaire based on eight different resuscitation scenarios. The outcome from both the healthcare professionals and the lay people was negative. Visible bleeding and an unsuccessful outcome significantly influenced both healthcare professionals' and lay people's perceptions. Female physicians and nurses reacted more negatively to family presence than did male physicians and nurses; laymen responded more negatively than lay women. To change the negative perceptions the facility must change its policy and then provide education to the healthcare professionals and the family members as well as training healthcare professionals to support the family members at bedside.

Family presence is highly recommended by many health organizations worldwide for several reasons including patient and family rights. There are no policies or guidelines in Saudi Arabia to guide health professionals in their practice regarding the option of family being present during resuscitations. The purpose of this study by Al-Mutair, Plummer, and Copnell (2012) was to identify the attitudes of nurses towards family presence during resuscitation in the Muslim community of Saudi Arabia. This is a descriptive study using data from a convenience sample of 132 nurses using a self-administered questionnaire. The study took place in two major trauma centers in the eastern region of Saudi Arabia. The analysis of the data revealed that nurses had negative attitudes towards family presence during resuscitation. A high percentage agreed that witnessing resuscitation is a traumatic experience for the family members. Almost all participants disagreed with the statement that the practice of allowing family members to be present during the resuscitation of a loved one would benefit the patient and 78% disagreed with the statement that it would benefit families. The majority of the participants revealed that the

presence of family would negatively affect the performance of the resuscitation team. However, almost half of the sample would prefer a written policy allowing the option of family presence during resuscitation in Saudi Arabia. The findings of the study strongly suggested the need for the development of written policies offering families the option to remain with patients during resuscitation in Saudi Arabia. The study further recommended the development of policies for healthcare professionals and the public for the safe implementation of the practice.

In discussing the practice of FPDR there are a number of perceived benefits and barriers to family presence during resuscitation (FPDR) in the emergency department, and debate continues among health professionals regarding the practice of family presence. This review of the literature aims to develop an understanding of the perceived benefits, barriers, and enablers to implementing and practicing FPDR in the emergency department. The perceived benefits include helping with the grieving process, everything possible was done, facilitates closure and healing, and provides guidance and family understanding and allows relatives to recognize efforts. The perceived barriers include increased stress and anxiety, distraction by relatives, fear of litigation, traumatic experience, and family interference. There were four sub themes that emerged from the literature around FPDR. These included the need for a designated support person, the importance of training and education for healthcare professionals, and the creation of a formal policy within the emergency department. Emergency healthcare workers need to understand the need for advanced FPDR training and education, the importance of a designated support person role and the evidence of FPDR policy as enablers to implementation (Porter, Cooper, & Sellick, 2014).

A study was conducted to measure the impact of intensive care unit environments on nurse perception of family presence during resuscitation and invasive procedures. The study used a design with nurses from intensive care units using the Family Presence Self-confidence Scale for resuscitation/invasive procedures that measures nurses' perception of self-confidence and Family Presence Risk-Benefit Scale for resuscitation and invasive procedures that measures nurses' perception of risks/benefits related to managing resuscitation and invasive procedures with family present. There were significant differences in self-confidence, with medical and pediatric intensive care unit nurses rating more self-confidence for family presence during resuscitation. There were significant differences in risks/benefits with medical and pediatric intensive care unit nurses rating lower risk and higher benefit for resuscitation. Perceptions of family presence were significantly higher for pediatric and medical intensive care unit nurses. Further education and support may be needed in the surgical and mixed intensive care units as compared to the critical care and emergency units. Evidence-based practice guidelines that are family centered can define the procedures and resources for family presence, to ultimately promote professional practice (Carroll, 2014).

Twibell et al. (2008) developed a survey tool to examine the relationship between nurses' self confidence in providing care and support of families during resuscitation and support of family presence during resuscitation in relation to the risk or benefit of such actions. Results showed a positive correlation between nurses' self confidence in caring for the families during resuscitation and their support of family presence during resuscitation. It was unclear as to whether self-confidence resulted in or was the result of adoption of family presence during resuscitation. The researchers found that nurses who common-

ly invite family members into the room during resuscitation demonstrate more confidence and are more likely to repeat that action.

Family witnessed resuscitation is the practice of enabling patients' family members to be present during resuscitation. Research is inconsistent as to the effectiveness or usefulness of this initiative. A study by Chapman, Watkins, Bushby, and Combs (2013) evaluated the performance of two scales that assessed perceptions of family witnessed resuscitation among a sample of health professionals, in an Australian non-teaching hospital, and explored differences in perceptions according to sociodemographic characteristics and previous experience. An anonymous survey was distributed to 221 emergency department clinicians. Sociodemographic characteristics and perceptions of family witnessed resuscitation using the Family Presence Risk–Benefit and Family Presence Self-confidence Scales were assessed. One hundred and fourteen doctors and nurses returned the survey. Approximately two-thirds of participants considered that family presence was a right of patients and families, and almost a quarter of respondents had invited family presence during resuscitation on more than five occasions. They found no significant differences in scale scores between doctors and nurses. Their findings confirmed the need to support clinicians in the provision of family witnessed resuscitation to all families.

Duran, Oman, Abel, Koziel, and Szymanski (2007) surveyed nurses and physicians practicing in the neonatal intensive care, adult critical care and the emergency department of a large western academic hospital. The researchers found that those that had experience with family presence during resuscitation were more supportive than those that did not have any experience. The researchers used a survey tool that was designed to

collect data on providers' attitudes and beliefs regarding family presence during resuscitation. The study also showed greater support by the nurses than the physicians.

Another study was completed to compare the view of accident and emergency healthcare professionals based in primary (out-of-hospital) and secondary (in-hospital) environments of care. The controversial practice of FPDR of adults has stimulated debate over the past two decades, giving rise to a growing body of literature and the development of clinical guidelines for practice. Eighteen studies were included in the critical review, primarily comprising retrospective survey research. The findings revealed that accident and emergency healthcare professionals perceived both positive and negative effects as a consequence of family presence during adult resuscitation and their opinions suggested that there were more risks than benefits (Walker, 2008).

Increasingly, patients' families are remaining with them during cardiopulmonary resuscitation and invasive procedures, but this practice remains controversial and little is known about the practices of critical care and emergency nurses related to family presence. A survey was mailed to a random sample of members of the American Association of Critical-Care Nurses and the Emergency Nurses Association. Among the 984 respondents, 5% worked on units with written policies allowing family presence during both resuscitation and invasive procedures and 45% and 51%, respectively, worked on units that allowed it without written policies during resuscitation or during invasive procedures. Some respondents preferred written policies allowing family presence, whereas others preferred unwritten policies allowing it. Many respondents had taken family members to the bedside or would do so in the future. Nearly all respondents had no written policies for family presence yet most had done it, prefer it be allowed, and are confronted with

requests from family members to be present. Written policies or guidelines for family presence during resuscitation and invasive procedures are recommended (MacLean et al., 2003).

The practice of allowing family to be present during patient resuscitation or invasive procedures is gaining acceptance in controlled circumstances. Hodge and Marshall (2009) discussed research into FPDR has demonstrated multiple benefits for the patient, family, and health care team. These advantages included helping the family to understand the severity of the illness or trauma and to see that appropriate attempts were undertaken to save their loved one. Family presence can also facilitate improved communication between the health care team and family. In spite of evidence supporting family presence as a useful practice for patient, family and health care team, resistance is also evident. A critical component of a successful Family Presence program is a family facilitator who is adequately prepared for the role and committed to supporting the family during resuscitation or invasive procedures.

CHAPTER III

Methodology

The opinions of healthcare providers differ according to their profession, specialty, and level of experience. Surveys have shown that between 86% and 96% of nurses endorse FPDR compared to 50% to 79% of physicians (Critchell, 2007). A survey of 554 health professionals who had all attended at least one resuscitation showed that 43% of nurses and 20% of physicians were in favor of FPDR in adult patients (McClenathan et al., 2002). Additional surveys showed that healthcare professionals' attitudes towards FPDR can evolve positively over time. The purpose of this MSN thesis was to investigate healthcare professionals' perceptions related to family presence during resuscitation.

Implementation

Family presence at bedside during resuscitation can be an important component of the patient's care and the family's recovery. Historically, many departments do not allow the family members inside the room during resuscitation efforts. Although more healthcare professionals are beginning to have positive perceptions regarding family presence during resuscitation, a majority of facilities do not have written guidelines or an established policy regarding this process. There are a multitude of reasons as to why this is not allowed. The healthcare professionals feel as though the family presence could distract healthcare professionals from performing their duties, violate patient confidentiality, and expose the family to traumatic events. Many of these reasons are based on healthcare professionals' perceptions of any perceived problems that may occur during resuscitation. Even with the negativity towards this practice, it is beginning to gain

recognition and has the potential to have a significant impact on nursing practice and personnel. Some institutions support and recommend having family members present during resuscitation as it can offer benefits to both patients and family members.

Healthcare professionals' perception of FPDR varies throughout job roles, age, gender, and other demographics. A quantitative approach was used for this study. A survey questionnaire was utilized which also included demographic items. The survey was developed by Dr. Renee Twibell for research regarding FPDR. These questions asked the healthcare professionals to describe their perceptions of family presence during resuscitation. The questions addressed such factors as the healthcare professionals' attitudes regarding death, dying, and the grieving process which can be shaped by the person's background and personal experiences. The next factor relates to the healthcare professional's personal values such as compassion, caring, and respect. The third factor relates to healthcare professionals' feelings of doubt, insecurity, fear, and inadequacy. The final factor relates to the healthcare professionals' perception of their ability to perform their regular tasks and job duties during resuscitation with the family at the bedside. This is related to their physical abilities, their work expertise, and experience. An anonymous, self-administered questionnaire was distributed to the nursing healthcare professionals at a chosen medical facility to assess their perceptions of FPDR. Perceptions of self-confidence, risks, and benefits were assessed as well as a 20 item family presence risk-benefit scale and a 16 item family presence self-confidence scale utilizing the tool created by Dr. Renee Twibell. Permission to use the original questionnaire was requested and granted from Dr. Twibell.

Participants were sent a consent form explaining the purpose and procedure of the study, as well as the voluntariness, risks and benefits, confidentiality and whom to contact with questions. The participants were informed that their participation was voluntary and consent was provided by return of a completed survey.

Setting

The setting for this study was an acute care hospital located in the southeastern United States. The facility offered three inpatient nursing units which consisted of Medical/Surgical, Progressive Care Unit, Intensive Care Unit, and an Emergency Department.

Sample

The participants were acquired through convenience sampling. Participants were registered nurses or licensed practical nurses. The target sample was recruited by asking each nurse manager to share the survey with their staff nurses through healthcare professionals meetings, e-mail, and daily huddles. The survey was distributed to approximately 100 nurses with 59 surveys returned. The questionnaire collected sociodemographic data including age, gender, race, ethnicity, role, highest education, years of experience, presence of clinical specialty certification and professional organization membership. The participants were also asked to report how many times they had invited family members to be present during resuscitation and whether or not they would want their family members to be present if they were a patient being resuscitated or if they would want to be present if it was their family member being resuscitated. The participants were also asked who is the best one to make the decision about family presence during

resuscitation and if the decision about family presence should be a part of an advanced directive authorized by the patient.

The survey required the participants to rate their agreement with the items using a five point Likert scale which ranged from strongly disagree (1) to strongly agree (5). The risk benefit higher scores indicated a greater level of perceived benefit to FPDR. The self-confidence scale higher scores indicated a greater level of self-confidence in managing family witnessed resuscitation. The surveys were completed and returned to the manila envelope in the nurse manager's office.

Design

This was a descriptive study. Participants were selected using convenience sampling techniques. Participants were given a consent form explaining the purpose and procedure of the study. Each participant was informed that their participation was voluntary and that they could refuse to participate, discontinue participation, or skip any questions they did not wish to answer at any time without penalty or loss of the benefits to which they are entitled. They were informed that their decision would not affect their employment. The risks and benefits were explained as they may experience some mild, temporary discomfort relating to answering some questions on the questionnaire as they concerned their feelings and attitudes. They were informed that they would probably not receive any direct benefits from participating in this research but that their participation would help hospital administrators understand their perception of family presence at bedside during resuscitation. The participants were informed that they would not receive any type of compensation for participating in the survey. Their confidentiality was explained as only the principal researcher would have access to research results associated

with their identity. It was explained that in the event of publication of this research, no personally identifying information would be disclosed. The participants were also given the contact information for the researcher for any questions regarding the research study and the number for the Institutional Review Board Office for any questions regarding their rights as a research participant. The participants were informed that their participation was voluntary and consent was provided by return of a completed survey.

Protection of Human Subjects

The study proposal was submitted to the university and the Facility Institutional Review Board (IRB). Upon approval, the participants were sent a consent form explaining the purpose and procedure of the study. Each participant was informed that their participation was voluntary and that they could refuse to participate, discontinue participation or skip any questions they did not wish to answer at any time without penalty or loss of the benefits to which they are entitled. They were informed that their decision would not affect their employment. Their confidentiality was explained as only the principal researcher would have access to research results associated with their identity. It was explained that in the event of publication of this research, no personally identifying information would be disclosed. The participants were also given the contact information for the researcher for any questions regarding the research study and the number for the Institutional Review Board office for any questions regarding their rights as a research participant. The participants were informed that their participation was voluntary and consent was provided by return of a completed survey.

Instruments

The Staff Perceptions of Family-Witnessed Resuscitation questionnaire was used to collect data for this study. Sociodemographic data including age, gender, race, ethnicity, role, highest education, years of experience, presence of clinical specialty certification, and professional organization membership was also collected. The participants were also asked to report how many times they had invited family members to be present during resuscitation and whether or not they would want their family members to be present if they were a patient being resuscitated or if they would want to be present if it was their family member being resuscitated. The participants were also asked who is the best one to make the decision about family presence during resuscitation and if the decision about family presence should be a part of an advanced directive authorized by the patient.

The survey required the participants to rate their agreement with the items using a five point Likert scale which ranged from strongly disagree (1) to strongly agree (5). The risk benefit higher scores indicated a greater level of perceived benefit to FPDR. The self-confidence scale higher scores indicated a greater level of self-confidence in managing family witnessed resuscitation.

Data Collection Procedure

The participants were acquired through convenience sampling. The target sample was recruited by asking each nurse manager to share the survey with their staff nurses through healthcare professionals meetings, e-mail, and daily huddles. Each staff nurse was given a copy of the consent and the survey. They were asked to complete and return the survey to the manila envelope in the nurse manager's office.

Data Analysis

The narrative responses were analyzed by the researcher for recurring themes and factors.

Summary

An anonymous, self-administered questionnaire was distributed to the nursing healthcare professionals at a chosen medical facility (N=59) to assess their perceptions of FPDR. Healthcare professionals' perception of FPDR varies throughout job roles, age, gender and other demographics. A quantitative approach was used for this study. Perceptions of self-confidence, risks, and benefits were assessed as well using the Staff Perceptions of Family-Witnessed Resuscitation survey, containing a 20 item family presence risk-benefit scale and a 16 item family presence self-confidence scale. Participants were sent a consent form explaining the purpose and procedure of the study, the voluntariness, risks and benefits, confidentiality and whom to contact with questions. The participants were informed that their participation was voluntary and consent was provided by the return of a completed survey.

CHAPTER IV

Results

A total of 59 surveys were returned for analysis. The responses from each of the surveys were coded and entered into Statistical Package for the Social Sciences (SPSS). Table 1 shows the demographic profile of the respondents. The profile of the typical respondent was a white female with an associate degree employed in an emergency department with more than 22 years of experience.

Table 1.

Demographic profile of respondents (N = 59)

	N	%
Race/Ethnicity		
Caucasian	56	94.9
African American	2	3.4
Hispanic	1	1.7
Gender		
Male	13	22
Female	46	78
Current Nursing Role		
RN	57	96.6
LPN	2	3.4
Years of Experience		
<1	2	3.4
1 - 5	9	15.3
6 - 10	10	16.9
11 - 20	12	20.3
>20	26	44.1
Highest Degree		
LPN	2	3.4
Associate	34	57.6
Bachelor's	21	35.6
Master's	2	3.4
Usual Work Setting		
Emergency Department	29	49.2
Critical Care Unit	13	22
Non-Critical Care	13	22
Other	4	6.8

Items 1 - 43 of the survey were answered by the respondents using a 5-point Likert scale with the following response options: 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree and 5 = strongly agree. Seven items were reverse coded. In order to maintain consistency in the direction of coding, the responses were reversed in the analysis (e.g., a score of "1" was coded as "5"). In order to avoid a separate statistical analysis of each of the 43 items and to provide some clarity to the results, a factor analysis using Varimax rotation was performed to determine if the items of the survey could be reduced to a set of principal components or domains. In the analysis only rotated factors with eigenvalues greater than one were included.

The analysis revealed that all 43 items loaded strongly on five factors, which accounted for 66.1% of the total variance in the sample. A review of the item loadings was performed to determine the essence of the five factors. Factor 1 relates to the healthcare professional's own attitude regarding death/dying and the grieving process (shaped by the person's background and personal experiences). This factor was identified as "Attitude". It included not only healthcare professionals' own beliefs about death and dying but also their opinions about how family members feel about it.

Factor 2 relates to the healthcare professionals' personal values - compassion, caring and respect, and was labeled as "Values" in this analysis. Factor 3 relates to healthcare professionals' feelings of doubt, insecurity, fear, failure, and inadequacy and was identified as "Fears". Factor 4 relates to healthcare professionals' perception of their ability to perform their regular tasks and job duties and was identified as "Efficacy" in the analysis. Factor 5, a single item, refers to concern about the family reaction to the resuscitation, i.e., whether they will be disruptive. This factor is referred to as "Family

Behavior" and identifies the healthcare professionals' concern about how family members might behave during resuscitation. Table 2 shows the means and standard deviations of each of the factors identified.

Table 2.

Descriptive statistics on the five factors

Factor	N	Minimum	Maximum	Mean	SD
Attitude	59	1.65	4.80	3.28	.72
Values	59	2.17	5.00	4.02	.64
Fears	59	2.20	4.00	3.05	.37
Efficacy	59	3.00	4.80	4.11	.48
Family Behavior	59	1.00	5.00	3.23	.89

The range of respondents was limited in a number of areas, e.g., race/ethnicity, degree attained. Twenty-two percent of the respondents were male. In the area of experience, the sample divided fairly evenly between those with less than 20 years of experience versus those with 20 or more years of experience. Additionally, almost half of the respondents (49.2 %) work in an emergency department. To determine whether the factor scores differed based on gender, experience or work setting, t-tests were performed to determine if the factor scores differed significantly based on these demographics. All analyses were performed with $p = .05$.

Males (N = 13) had higher scores compared to females (N = 46) for factors 1 and 2 (Healthcare professionals' Attitude and Healthcare professionals' Values). The results suggested that males believe that they and family members have a more positive view towards the death/dying process, e.g., that being present during resuscitation improves the grieving process and that there will be a generally more positive view of the situation. The data indicated that in this sample of respondents, males believe themselves to be more caring and compassionate towards the family members especially during the midst of the situation, e.g., provide comfort and enlist support from others as needed. Table 3 shows the results for factor score comparisons based on gender.

Table 3.

Factor score differences based on gender (N = 59)

Factor	t	df	p	Mean Difference
F1: Healthcare professionals' Attitude	2.4	57	.01	.52
F2: Healthcare professionals' Values	2.2	57	.03	.43
F3: Healthcare professionals' Fears	.9	57	.93	-.001
F4: Healthcare professionals Efficacy	1.6	57	.10	.25
F5: Family Behavior	1.8	57	.09	.48

There were no differences on the factor scores based on years of experience. One item on the survey identified the unit on which the respondent most often worked. This item was recoded so that respondents working in emergency departments could be compared to those who primarily work elsewhere. No significant differences were found.

The overall results show that the respondents have a neutral opinion on three of the five factors: attitudes, fears, and family behaviors. The two factors where the respondents had the highest scores (indicative of more positive beliefs) were in the area of values and efficacy. Those two areas related more to the healthcare professionals personally. The data suggested that healthcare professionals have positive beliefs about their personal levels of caring and compassion. This factor is less influenced by family members or their beliefs. Similarly, the efficacy factor may be rated more positively because it is a function of their beliefs about their own skills and knowledge. The remaining three factors have more neutral mean scores that may be a function of the influence of uncertainty about how family members feel about being present during resuscitation (regardless of their own beliefs).

Seven items provided additional information on the respondents' experiences and their beliefs. These items were analyzed independently and are reported below. Table 4 presents information on presence during resuscitation: their own desires, experiences with their own family and whether the patient wishes should be identified through an advanced directive. There was a higher percentage of respondents who did not favor family members being present during resuscitation of themselves and few have experienced resuscitation of a family member. An overwhelming majority believe that the presence of a family member during resuscitation should be identified by an advanced directive.

Table 4.

Questions relating to presence during resuscitation (N = 59)

Question	% Yes	% No
If you were a patient who was being resuscitated, would you want your family members present in the room?	40.7	50.3
Have you ever been present in the room during the resuscitation of one of your family members?	28.8	71.2
Should the decision about family presence be part of an advanced directive authorized by the patient?	81.7	15.3

One question asked the respondent to identify the person who should make the decision about a family member being present during resuscitation (including the patient through an advanced directive). Figure 1 shows the results of this analysis.

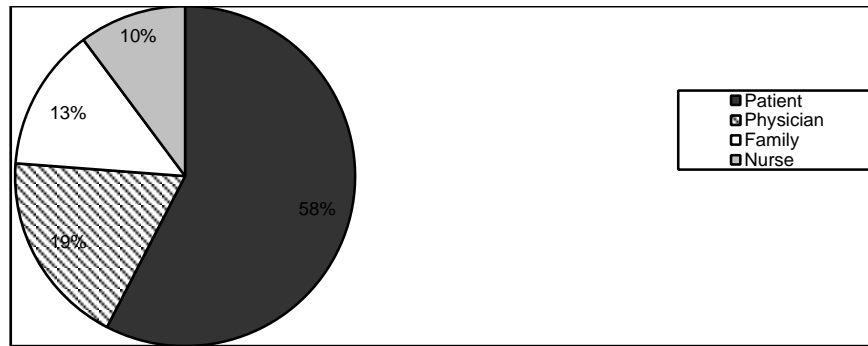


Figure 1. *Response to question (N = 59) regarding who should make the decision about family members being present during resuscitation.*

The final analyses had to do with the unit where the healthcare professionals worked the last time they invited a family member to a resuscitation attempt and the number of times they invited a family member to be present during a resuscitation attempt. Figures 2 and 3 show these results.

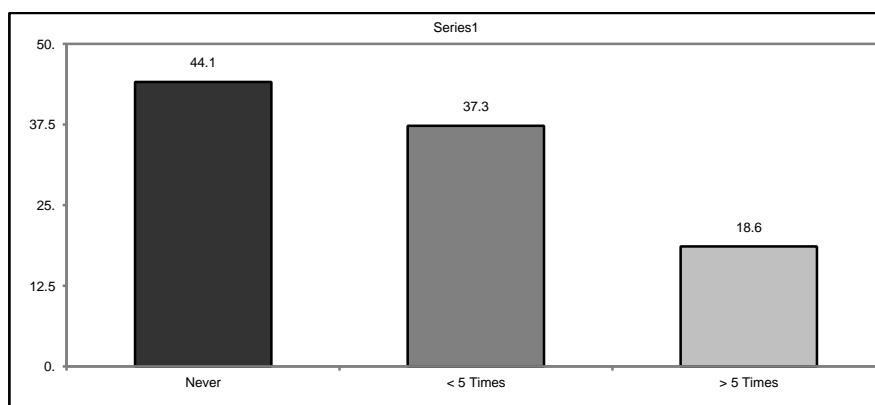


Figure 2. *Number of times respondent invited a family to be present during a resuscitation attempt (N = 59)*

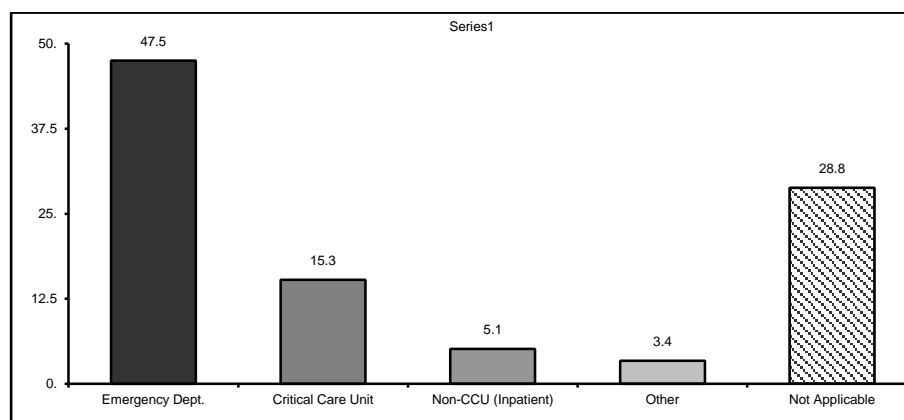


Figure 3. *Unit healthcare professionals worked the last time they invited a family member to a resuscitation (N = 59)*

Results

The purpose of this research study was to evaluate the perception of healthcare professionals regarding family presence during resuscitation. The participants were acquired through convenience sampling. The target sample was recruited by asking each nurse manager to share the survey with their healthcare professionals through healthcare professionals meetings, e-mail and daily huddles.

The literature review for this research study found numerous research articles supporting the presence of family at bedside during resuscitation. The aim of this research study was to evaluate the perception of healthcare professionals regarding family presence during resuscitation. The primary investigator's intention was to discover information that may useful to initiate a policy and procedure regarding family presence at bedside during resuscitation.

Descriptive Analysis of the Demographic Data

The range of respondents was limited in a number of areas, e.g., race/ethnicity, degree attained. Twenty-two percent of the respondents were male. In the area of experience, the sample divided fairly evenly between those with less than 20 years of experience versus those with 20 or more years of experience. Additionally, almost half of the respondents (49.2 %) work in an emergency department. To determine whether the factor scores differed based on gender, experience or work setting, t-tests were performed to determine if the factor scores differed significantly based on these demographics. All analyses were performed with $p = .05$.

Males ($N = 13$) had higher scores compared to females ($N = 46$) for factors 1 and 2 (Healthcare professionals' Attitude and Healthcare professionals' Values). The results suggested that males believe that they and family members have a more positive view towards the death/dying process, e.g., that being present during resuscitation improves the grieving process and that there will be a generally more positive view of the situation. The data indicated that in this sample of respondents, males believe themselves to be more caring and compassionate towards the family members especially during the midst of the situation, e.g., provide comfort and enlist support from others as needed.

There were no differences on the factor scores based on years of experience. One item on the survey identified the unit on which the respondent most often works. This item was recoded so that respondents working in emergency departments could be compared to those who primarily work elsewhere. No significant differences were found.

The overall results showed that the respondents had a neutral opinion on three of the five factors: attitudes, fears, and family behaviors. The two factors where the re-

spondents had the highest scores (indicative of more positive beliefs) were in the area of values and efficacy. Those two areas related more to the healthcare professionals personally. The data suggested that healthcare professionals had positive beliefs about their personal levels of caring and compassion. This factor is less influenced by family members or their beliefs. Similarly, the efficacy factor may be rated more positively because it is a function of their beliefs about their own skills and knowledge. The remaining three factors have more neutral mean scores that may be a function of the influence of uncertainty about how family members feel about being present during resuscitation (regardless of their own beliefs).

Seven items provided additional information on the respondents: their experiences and their beliefs. When asked about their own desires, experiences with their own family and whether the patient wishes should be identified through an advanced directive, there was a higher percentage of respondents who did not favor family members being present during resuscitation of themselves and few have experienced resuscitation of a family member. An overwhelming majority believed that the presence of a family member during resuscitation should be identified by an advanced directive.

One question asked the respondent to identify the person who should make the decision about a family member being present during resuscitation (including the patient through an advanced directive), 58.8% believed that it should be the patient who makes the decision while 19% felt it is the duty of the physician and 14% felt it was the family. Only 10% of those surveyed felt that it should be the nurse's decision.

The final analyses had to do with the unit where the healthcare professionals worked the last time they invited a family member to a resuscitation attempt and the

number of times they invited a family member to be present during a resuscitation attempt. 44.1% of the healthcare professionals have never invited a family member to be present during resuscitation while 37.3% had invited families greater than five times and 18.6% have invited families less than five times. The units that this happened most frequently in are the ED at 47.5%, Critical Care at 15.3%, Inpatient at 5.1%, other at 3.4% while 28.8% were not applicable.

Research Question 1

The first research question was “What are the most frequently perceived opinions among nursing healthcare professionals regarding FPDR?”

There were a higher percentage of respondents who did not favor family members being present during resuscitation of themselves and few have experienced resuscitation of a family member. Despite their disfavor of their family at bedside, many of the respondents felt that the presence of family members during resuscitation will have a positive effect on patient, family, nurse, and physician satisfaction with hospital care. In addition, the respondents felt that the family presence during resuscitation could be beneficial to families, nurses and physicians. They also agreed that it is a right that all patients and family members should have available if desired. An overwhelming majority believed that the presence of a family member during resuscitation should be identified by an advanced directive. The respondents were asked to identify the person who should make the decision about a family member being present during resuscitation (including the patient through an advanced directive), 58% believed that it should be the patient who makes the decision while 19% felt it is the duty of the physician and 14% felt it was the family. Only 10% of those surveyed felt that it should be the nurse’s decision.

Research Question 2

The second research question was “What are the perceived performance behaviors that nursing healthcare professionals feel they can comfortably complete with FPDR?”

The two factors where the respondents had the highest scores (indicative of more positive beliefs) were in the area of values and efficacy. Those two areas related more to the healthcare professionals personally. The efficacy factor may be rated more positively because it is a function of their beliefs about their own skills and knowledge. The respondents felt quite confident that they could administer drugs, perform electrical therapies and deliver chest compressions with the families present in the room. The remaining factors have more neutral mean scores that may be a function of the influence of uncertainty about how family members feel about being present during resuscitation (regardless of their own beliefs). The data suggested that healthcare professionals have positive beliefs about their personal levels of caring and compassion. This factor is less influenced by family members or their beliefs.

Research Question 3

The third research question was “What are the relationships between selected demographic characteristics and perceived opinions?”

Males (N = 13) had higher scores compared to females (N = 46) for factors 1 and 2 (Healthcare professionals Attitude and Healthcare professionals Values). The results suggested that males believe that they and family members have a more positive view towards the death/dying process, e.g., that being present during resuscitation improves the grieving process and that there will be a generally more positive view of the situation.

The data indicated that in this sample of respondents, males believe themselves to be more caring and compassionate towards the family members especially during the midst of the situation, e.g., provide comfort and enlist support from others as needed.

There were no differences on the factor scores based on years of experience. One item on the survey identified the unit on which the respondent most often works. This item was recoded so that respondents working in emergency departments could be compared to those who primarily work elsewhere. No significant differences were found.

Summary

The purpose of this research study was to evaluate the perception of healthcare professionals regarding family presence during resuscitation. Many of the respondents felt as though the patient had the primary right to choose if they wanted family at bedside although it could also be done at the discretion of the physician. Many responses were neutral regarding their attitudes regarding death, dying, and the grieving process as well as their own fears or feelings of insecurity with the family present during resuscitation. The largest variance was noted between male and female as the males seemed to feel as though they have a more positive attitude and that they are more caring and compassionate. Race, age, years of experience, and the primary department worked did not show any significant differences.

CHAPTER V

Discussion

The purpose of this study was to examine the perception of healthcare professionals regarding family presence during resuscitation. The sample consisted of 59 nurses of different ages and working in different departments. The relationships between participants' demographic data and perceived attitudes and beliefs were also analyzed. The results elicited from this study identified several barriers and benefits to family presence at bedside during resuscitation.

Significance of the Findings

There is an awareness of the barriers and benefits to family presence during resuscitation. Many of the healthcare professionals felt that it was acceptable if the patient makes clear decisions prior to the incident or if the physician makes the decision for the patient. Almost half of the healthcare professionals have invited family members to the bedside during resuscitation. The healthcare professionals did not respond as having negative attitudes or fears regarding this process. Many of the healthcare professionals responded with a positive attitude towards family presence during resuscitation. This presents an opportunity to investigate the possibility of a policy or procedure on this issue.

Implications for Nursing Practice

The research and the literature published showed a definite need to address this issue. The first step will be to establish a facility policy and procedure to ensure a positive family presence during resuscitation for the patient, family, and healthcare professionals. The Emergency Nurses Association, the American Heart Association, the American Association of Colleges of Nursing, and the National Association of Social Workers

approved of the process and have implemented guideline recommendations (Duran et al., 2007). The policy must be specific and fit the needs of the patient, the families and the healthcare professionals. The American Heart Association recommended that there be one healthcare professional assigned to the family to keep them updated and to explain each step and procedure as well as to provide emotional support. The next step would be to provide comprehensive education and yearly competencies for all healthcare professionals and physicians. The education would promote understanding of the processes as well as expectations during the resuscitation. This approach to care would provide compassionate and caring healthcare and decrease variations in practice caused by differences in healthcare professionals' attitudes.

Limitations of the Study

The majority of the respondents were from the emergency department, with representation lower in other areas. Another limitation was the lack of responses from physicians and physician extenders. The physicians played a large role in the resuscitation efforts and their attitudes and beliefs will impact their practice. The lack of responses from family members and patients can also be seen as a limitation. Although this study focused on healthcare professionals, the beliefs and attitudes of patients and families are very important and should be explored.

Recommendations for Future Research

As stated above, physician, patient, and family members' beliefs and attitudes were instrumental in this process. Each has a large impact on this scenario and their beliefs and attitudes should be explored. Further research should be completed pre and post resuscitation both with family members and those patients that survive resuscitation.

Final Summation

Family presence during resuscitation has positive results for patients that survive, family members, and healthcare professionals. The presence of the families does not usually involve conflicts or interfere with medical efforts. The patient may directly benefit from the participation of their family members and the healthcare professionals will benefit as it results in improvement of patient care as well as patient and family outcomes.

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